HIGHLIGHT AND PLACE NAME HERE

Date of PSP: _____

Date of Dissemination: _____

Personal Support Plan

☐ Residential and Vocational/Day Services

☐ Residential Services Only

☐ Vocational/Day Services Only

☐ Self-Directed Services (must also complete the Self-Direct with Employer Authority Plan of Care)

☐ Case Management Only

☐ Other

☐ Initial

☐ Annual

☐Review/ Revision

☐ Exit

Residential Services = Residential Habilitation (group home and supported living), Adult Companion, Adult Foster Support, Assisted Living, and Live-in Caregiver.

This plan is approved. It is person-centered and the individual was involved in its development. The plan was developed based on assessments of the person's needs, vision, preferences and health and safety risk factors. In addition, all services listed on the person's cost plan are identified in actions in this plan of care.

Case Manager Signature: _____ Date: _____

Montana Department of Public Health & Human Services Developmental Disabilities Program
111 North Sanders
Helena, MT 59604-4210
Phone: 406.444.2995 • Fax: 406 444 0230

Do not alter this document except where indicated. Mark n/a or otherwise if there is no information for a given section.

Index

S E C T I O N I V
(Required for all PSPs – can be brief if not in a Residential and/or Vocational/Day Services)

Lifestyle

Communication

Home

Vocational/Retirement

- Provider responsible for completing as necessary to the services provided
- Case Manager responsible for completing if there is no provider

S E C T I O N V I I I
(Required for all PSPs)

Outcomes

- Case Manager responsible for completing based on input at team meeting

S E C T I O N I X
(Required for all PSPs)

Signatures

- Case Manager responsible for obtaining

Personal Support Plan

Section I. General Information Information Sheet	
Name:	
Address:	
City:	State: Zip Code:
Home Phone:	Work Phone:

People/Agencies Who Support Me

Note: Please list any Guardian or POA in the service/support provided section and Health Care Providers in the Wellness Section

Agency and/or contact person	Service/Support Provided	Address	Phone #	E-mail Address	Emergency Contact Y or N

Personal Support Plan

Name:	Effective Date of Plan:

Section II. Personal Introduction

Please see the PSP Procedure Manual for the type of information to be included in this section.

-
-
-

Personal Support Plan

Name:	Effective Date of Plan:

Section III. Personal Profile

Please see the PSP Procedure Manual for the type of information to be included in this section.

Important To: Includes things which help the person to be satisfied, content, comforted and happy	Important For: Includes things related to health and safety
• • •	• • •

Instructions For Supporters – What others need to know or do:
• • • •

Personal Support Plan

Name:	Effective Date of Plan:

Section IV. Lifestyle

Please see the PSP Procedure Manual for the type of information to be included in this section.

Communication:

What is Happening	Person Does This	What we think it means	We Should

Home:

Movement:

-

Eating/Nutrition:

-

Fun/Relationships:

-

Vocational/Day/Retirement :

Movement:

-

Eating/Nutrition:

-

Fun/Relationships:

-

Personal Support Plan

Name:	Effective Date of Plan:

Section V. Wellness

Please see the PSP Procedure Manual for the type of information to be included in this section.

Health Summary:

Physical Health:

-

Mental Health:

-

Hearing/Vision/Dental:

-

Allergies/Sensitivities			
Allergy/Sensitivity	**Reaction**	**Treatment**	**Precautions, Preventatives**

Equipment, Supplies & Technology			
Item	**Purpose**	**How Maintained/ Who Maintains**	**Date of Purchase**

Personal Support Plan

Name:	Effective Date of Plan:

Section V. Wellness

Medications

Include ALL PRN's and OTC's and attach PRN protocols.

Medication	Time(s) of Day Taken	Dosage/ Route	Purpose of Medication for this person	Start Date	Prescribing Professional

Additional Medication Information (e.g. precautions, preferences, interventions, presence of side effects, etc.):

Personal Support Plan

Name:	Effective Date of Plan:

Section V. Wellness Health Care Providers				
Name/Title	**Type of Services**	**Clinic (Facility) Name/Address**	**Phone**	**Last Significant Appointment**

Personal Support Plan

Name:	Effective Date of Plan:

Section VI. Personal Finance

Instructions: This form is intended to identify all the resources available to the person including their Individual Cost Plan (ICP) for DDP services. It can be used as an aid in the identification of solutions for any that may be lacking. This form can also be used to help identify options that may not have been used previously. "Other" may be used to identify such things as Veteran's Administration benefits or Railroad Retirement benefits.

Funding Source/Resource	**Yes**	**No**	**Amount**	**Funding Source/Resource**	**Yes**	**No**	**Amount**
ICP				SSI			
Title XIX (Waiver)				SSDI			
Title XX (non-Medicaid)				SSA			
Medicaid				State Supplement			
Medicare				TANF			
Family Education & Support				LIEAP			
Private Pay				Food Stamps (SNAP)			
Representative Payee				Housing Assistance			
Checking Account				Wages/period			
Savings Account				Retirement/period			
Medicaid Qualifying Burial Trust				Individual Indian Monies			
Medicaid Self-Sufficiency Trust				Bureau of Indian Affairs			
Credit Check				Other			

Questions to consider: Are there any monetary resources in safekeeping that might affect Medicaid eligibility? Have there been any changes in the past year that would affect the person's benefits (i.e. parent's death)? Does the person's income meet his or her expenses? Identify the Medicaid authorized representative, if there is one.

Personal Support Plan

Name:	Effective Date of Plan:

Section VII. Vision

Please see the PSP Procedure Manual for the type of information to be included in this section.

Personal Support Plan

Name:	Effective Date of Plan:

Section VII. Outcomes

Vision Statement:

Outcome: *Written to answer this question,:* **"What do I want to do this year?"**

Assessment tool/s used:

Actions (Approach): How do I get there? How will this be accomplished? *Include name of provider agency and title of responsible person.*	**Start Date/ Completion Date**	**Status/Progress**

Quarterly Status:

*Note: Quarterly schedule may be based on the actual date of the PSP **or** the calendar year. Indicate the schedule for this PSP below.*

Calendar Year ☐	Jan-Mar ☐	Apr-Jun ☐	Jul-Sep ☐	Oct-Dec ☐
Submitted by:	April 30th	July 30th	October 30th	January 30th
PSP Date ☐	☐	☐	☐	☐

Submitted within 30 days of the end of the quarter; fill in quarter date ranges above.

Updated by: Agency/Dept:

Additional Information:

Personal Support Plan

Name:	Effective Date of Plan:

Section VII. Outcomes

Vision Statement:

Outcome: *Written to answer this question,:* **"What do I want to do this year?"**

Assessment tool/s used:

Actions (Approach): How do I get there? How will this be accomplished? *Include name of provider agency and title of responsible person.*	**Start Date/ Completion Date**	**Status/Progress**

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Updated by: Agency/Dept:

Additional Information:

Personal Support Plan

Name:	Effective Date of Plan:

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Name:	Effective Date of Plan:

Section VII. Outcomes

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Submitted within 30 days of the end of the quarter; fill in quarter date ranges above.

Updated by: Agency/Dept:

Additional Information:

Personal Support Plan

Name:	Effective Date of Plan:

Section IX. Signatures

☐ Initial PSP ☐ Annual PSP ☐ PSP review/revision ☐ Exit PSP

My plan has been explained to me. I have been told what my rights are under my plan and I know that I may request another meeting, at any time, to make changes to my plan.

It has also been explained to me that the Department of Public Health and Human Services checks my progress in the plan. I have been assured that this information is kept confidential. Each member of my planning team will receive a copy of this plan.

Signature	Date

☐ The Person did not attend the meeting after attempting on two separate occasions. Please document above in the signature line the reasons the person did not attend and accommodations made to support the person in attending.

As a member of this team, my signature reflects my understanding of the confidential nature of the information contained and discussed in this plan. All decisions of the PSP team must be in consensus. My signature indicates that I consent to this plan. If attending meeting but not consenting, print name but leave signature line blank.

Signature indicates agreement with plan	Relationship to person	**Printed Name** indicates attendance at meeting

For Self-Directed Services only: I understand that failure to abide by the plan of care and performance benchmarks written to address problems identified in managing self-directed services may result in the involuntary termination of self-directed services. In this event, agency-based services may be made available.

_____ initials of individual/legal representative